Washington Rural Health Assessment Project

Access to Primary Health Care Services

Summary

Residents of rural communities in Washington experience different levels of access to primary health care. Some rural areas—particularly small town and isolated rural areas and the rural areas of urban counties—have shortages of primary care providers. But despite these shortages in some rural communities, adults living in Washington's large and small town rural areas are more likely than residents of urban areas to report having a usual place to receive medical care (89% v. 84%). Factors contributing to this situation include the greater role of primary care providers in rural health care delivery systems, differences in scale that make it easier to identify points of contact, and a more elderly population that has greater access to health care financing and primary care.

Rural Washingtonians are less likely to have health insurance than their urban counterparts, however. Rural residents have few insurance plans and options available to them. This is especially true for managed care options through Medicare and Medicaid. In 2002, the majority of physicians in most Washington counties were not accepting new Medicare and Medicaid patients. This fairly recent development is a growing problem in both rural and urban areas.

Medical transportation for the poor and elderly is also a serious concern. In 2001, half of Washington's rural counties had no public transportation services at all, and routes were very limited in many rural areas of urban counties.

American Indian and Hispanic populations—3% and 13% of Washington's large and small town rural population—are significantly less likely than the white population to have health insurance or a personal primary care provider.

The Washington Rural Health Assessment Project is a series of monographs on important trends influencing health status and health care access in rural Washington. These monographs are intended to supplement Washington State's Rural Health Plan. Other monographs will cover changes in demography, health care finance, health care services infrastructure, and special topics such as maternal and child health. These monographs are available on the Office of Community and Rural Health, Health Care Access Research web site: http://www.doh.wa.gov/hsqa/ocrh/har/hcresrch.htm.

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July 18, 2003

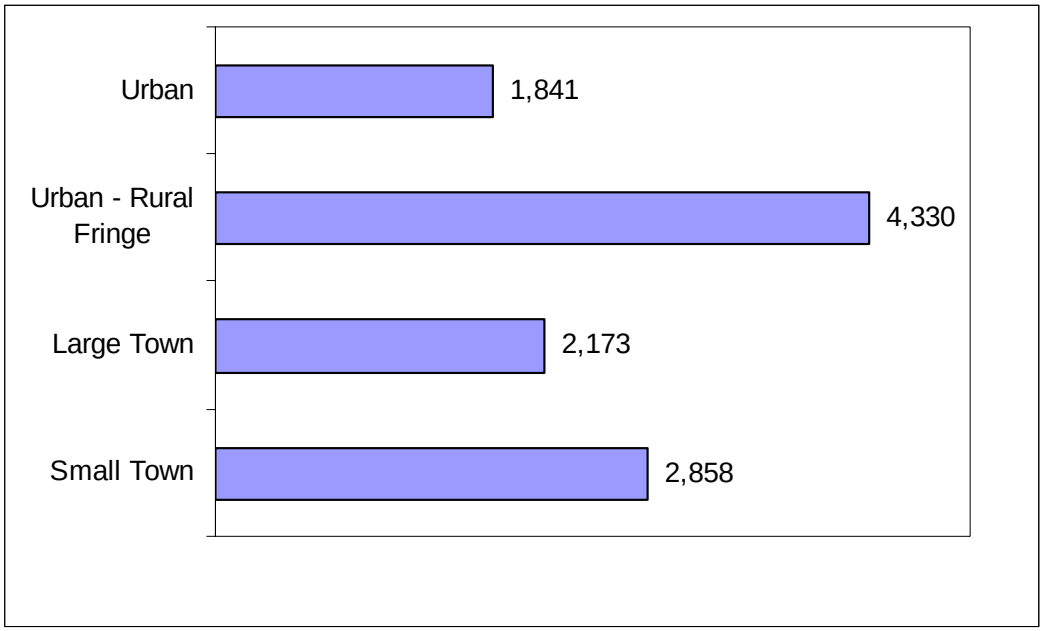
Washington State Department of Health

Access to Primary Care

Access to primary health care is a sentinel indicator of access to health services. The primary care provider provides initial access to the health services delivery system, early assessment, and preventive services. Adequate access requires a functioning health services infrastructure. Even if health services are available locally, they may not be accessible to those without health insurance, those who lack public and medical transportation services, or those who experience language and cultural barriers.

In general, the ratio of population to full-time primary care physicians in direct patient care is higher in rural areas. The higher ratio indicates a *shortage* of providers. The most recent comprehensive assessment of primary care infrastructure, conducted in 1998, revealed the worst shortages to be in the rural areas of urban counties. Ratios were well above the threshold that indicates serious shortage: 3,000 persons per full-time provider. In small town and large town areas, ratios exceeded 2,000:1, the threshold indicating stress and emerging shortages. The ratio for urban areas, 1,841:1, was in the upper end of range of typical values found in communities where some residents are not insured (between 1500:1 and 2,000:1). As a benchmark, in communities in which everyone has insurance, primary care access ratios are between 1,000:1 and 1,200:1.[i] The following table shows how the ratios compare across different types of rural communities in Washington.

Figure 1
Population per Primary Care Physician FTE
By Rural Classification in Washington, 1998



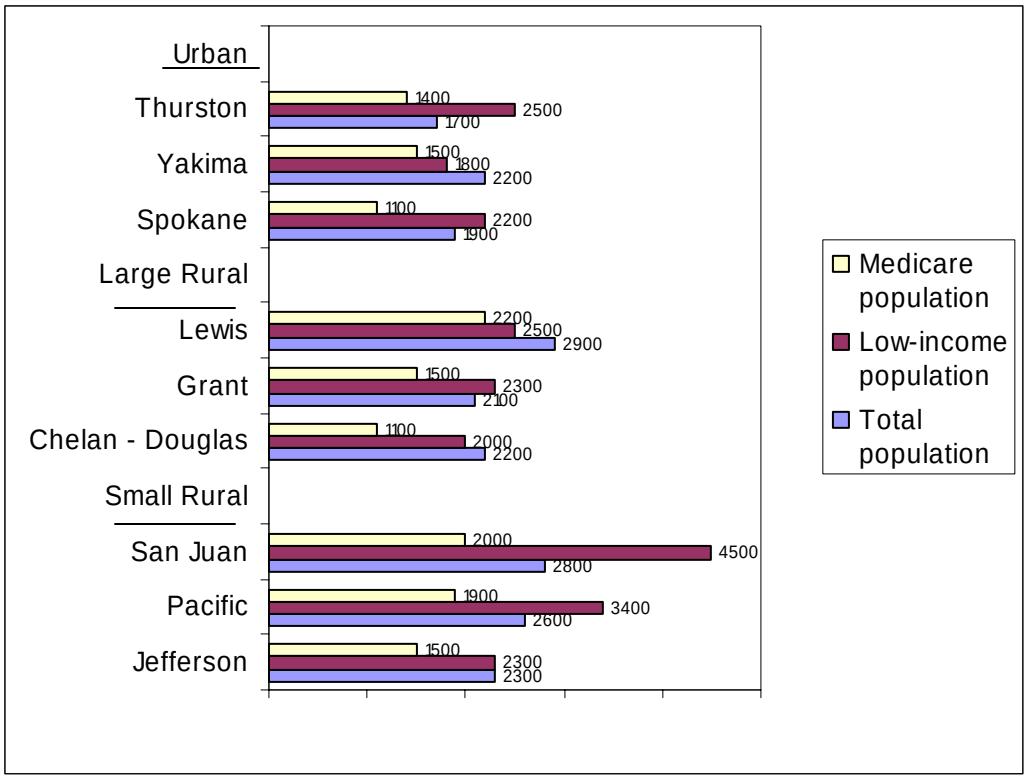
Source: Health of Washington State, 2002

More recent data, from Washington counties surveyed in 2002 and early 2003, verify the pattern found in 1998 and also provide information on how access differs for low-income residents and those enrolled in Medicare. Primary care physician availability for the total population is greater

in the more rural areas. But the data reveal a considerable variation across counties. Access for Medicare enrollees is in the ideal to normal range in most counties, whether urban or rural. Access for those with low-incomes is much worse in small rural areas.

Washington State health policy makers have worked to expand health care coverage to low-income households by expanding Medicaid eligibility and encouraging enrollment in the Basic Health Plan. As a result of these efforts, low-income residents' access to care in many counties is on par and in some cases even better than for the total population. But this improved access is expected to deteriorate as eligibility rules for publicly financed and subsidized care are tightened in response to current and future state budget deficits. The chart below shows differences in access across different types of rural counties.

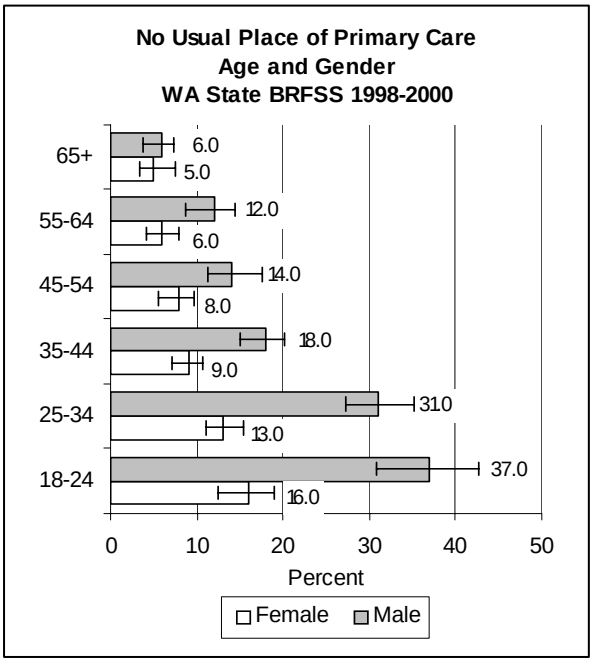
Figure 2
Population per Provider for Selected Washington Counties by Payer, 2002-03



Source: Office of Community and Rural Health

Data from Washington's 1998-2000 Behavioral Risk Factor Surveillance Survey suggest that primary care resources are tighter in rural areas, but adults living in large and small town rural areas were more likely than residents of urban areas to report having a usual place to receive medical care (89% vs. 84%). Several factors may contribute to this. Primary care physicians have a greater role in the rural health care delivery system than in the urban system. Rural Washington physicians see more patients and have higher volumes of outpatient visits than their urban counterparts.[ii] The scale of health care systems in rural areas is smaller than in urban areas, which may make it easier to identify points of contact and harder to refuse care. And as noted in the monograph on Aging and Long-term Care, the percent of the population that is elderly is higher in rural areas, and the elderly are more likely to have a usual source of care because they have Medicare coverage. The following Figure illustrates this connection between age and access.

Figure 3
Washington Residents With No Usual Source of Care, 1998-2000



Source: 1998-2000 BRFS, Health of Washington State, 2002

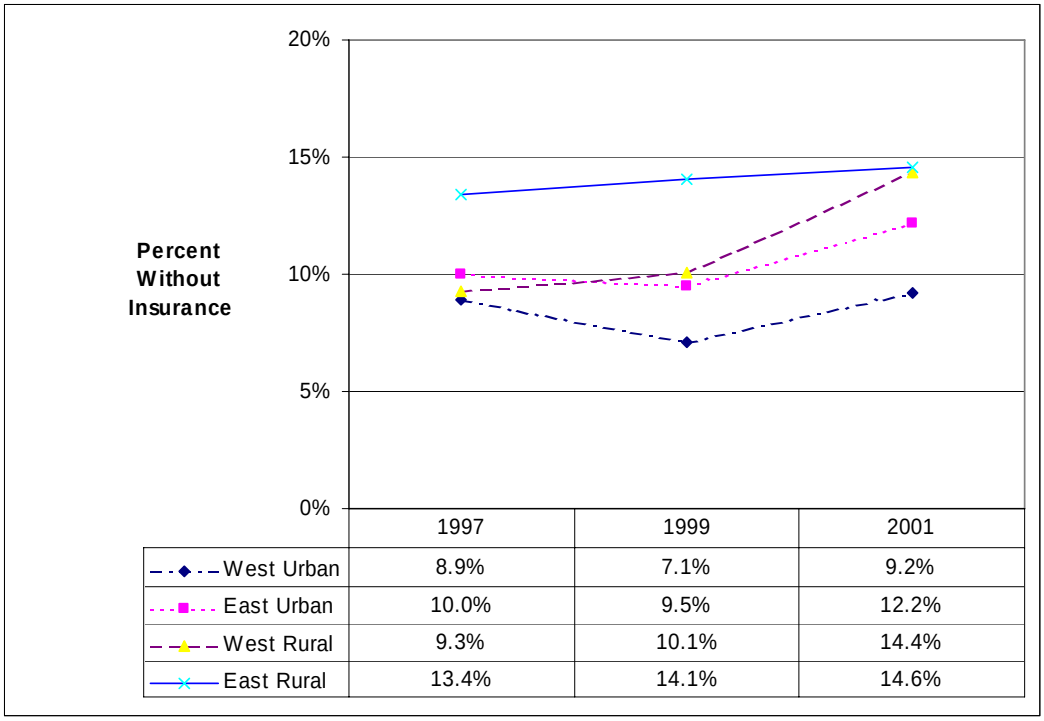
For more information on access to primary care in Washington, see **Health of Washington State, 2002**

Health Insurance

The federal Institute of Medicine's 2002 report on Care Without Coverage documents that people without health insurance have less access to health care services and much poorer health status than those with health insurance. The percent of Washington residents who reported in the State Population Survey that they did not have health insurance at the time they were surveyed declined during the late 1990s but then jumped up dramatically—from 8.4% in 1999 to 10.7% in 2001. The survey underestimates the level of the uninsured, as it doesn't address gaps in coverage. In the Census Bureau's Current Population Survey, a larger percent of Washington residents (13.1%) reported that they were uninsured for some part of 2001. A recent Henry J. Kaiser Foundation report found that about 45 million people across the country lacked coverage in 2003; when tracked over a year, 63 million persons lacked health insurance for a month or more.

The rates of those reporting they were currently uninsured in Washington's rural counties during 2001 were higher in both Eastern and Western Washington. The rates of uninsured in Eastern Washington historically have been higher, while those in Western Washington have only recently begun to climb. Rates in both rural and urban Washington are expected to increase further as the economy continues to stagnate, health insurance premiums continue to rise, and increasing medical costs and tight state revenues force further reductions in those covered through the Basic Health Plan and Medicaid.

Figure 4
Rates of Those without Health Insurance
In Washington's Urban and Rural Areas, 1997-2001



	1997	1999	2001
West Urban	8.9%	7.1%	9.2%
East Urban	10.0%	9.5%	12.2%
West Rural	9.3%	10.1%	14.4%
East Rural	13.4%	14.1%	14.6%

Source: State Population Survey, Office of Financial Management

Rural residents who have health insurance—whether public or private—have fewer options for care. Very few private insurance companies offer Medicaid managed care options in rural Washington. Consequently as of March 2003, only 2% of Medicare enrollees in small town counties and 8% of Medicare enrollees in large-town counties participated in Medicare managed care contracts, compared with 20% of Medicare enrollees in urban areas. Only 3 of 27 rural counties had more than two health plans participating in the Basic Health Plan, compared with 8 of 12 urban counties. And only five rural counties had more than two plans participating in Washington's Medicaid managed care program, Healthy Options, compared with six urban counties.

For more information on Washington health insurance trends and issues, see

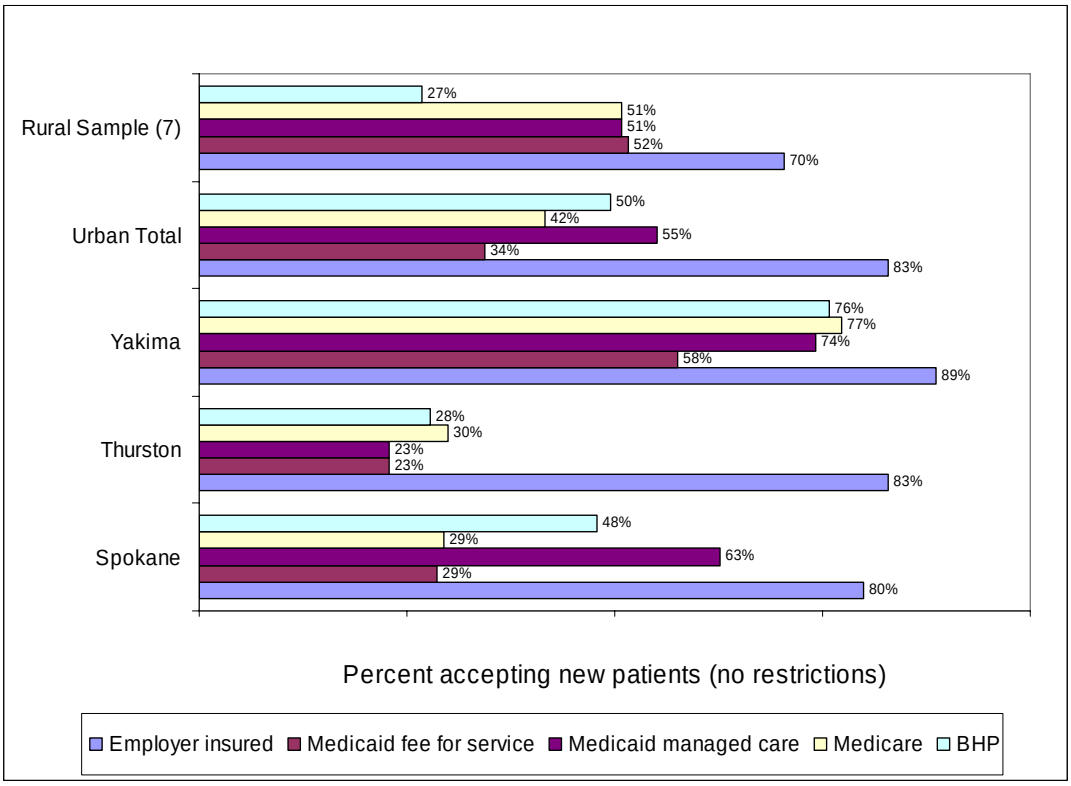
- Health of Washington State, 2002, Washington State Department of Health
- Washington State Planning Grant on Access to Health Insurance, Office of Financial Management

Availability of Primary Care Physicians to Public Patients

People with publicly provided or subsidized health care financing are not assured access to health care. This is the case even for those who live in communities with adequate numbers of providers. Recent state data show that, while primary care providers generally are continuing to see existing public patients, most are closing practices to new ones. The Office of Community and Rural

Health found in 2002 and early 2003 almost half the providers in both Washington's urban and rural counties reported they were closed to some or all new patients enrolled in Medicare, Medicaid, or the Basic Health Plan. In rural areas, providers were more likely to be closed to those with private insurance (a reflection of general provider shortages) and managed care options for Medicare, Medicaid, or the Basic Health Plan. But access for new public fee-for-service patients is worse in some urban counties. The following chart summarizes data from the 2002 and early 2003 surveys.

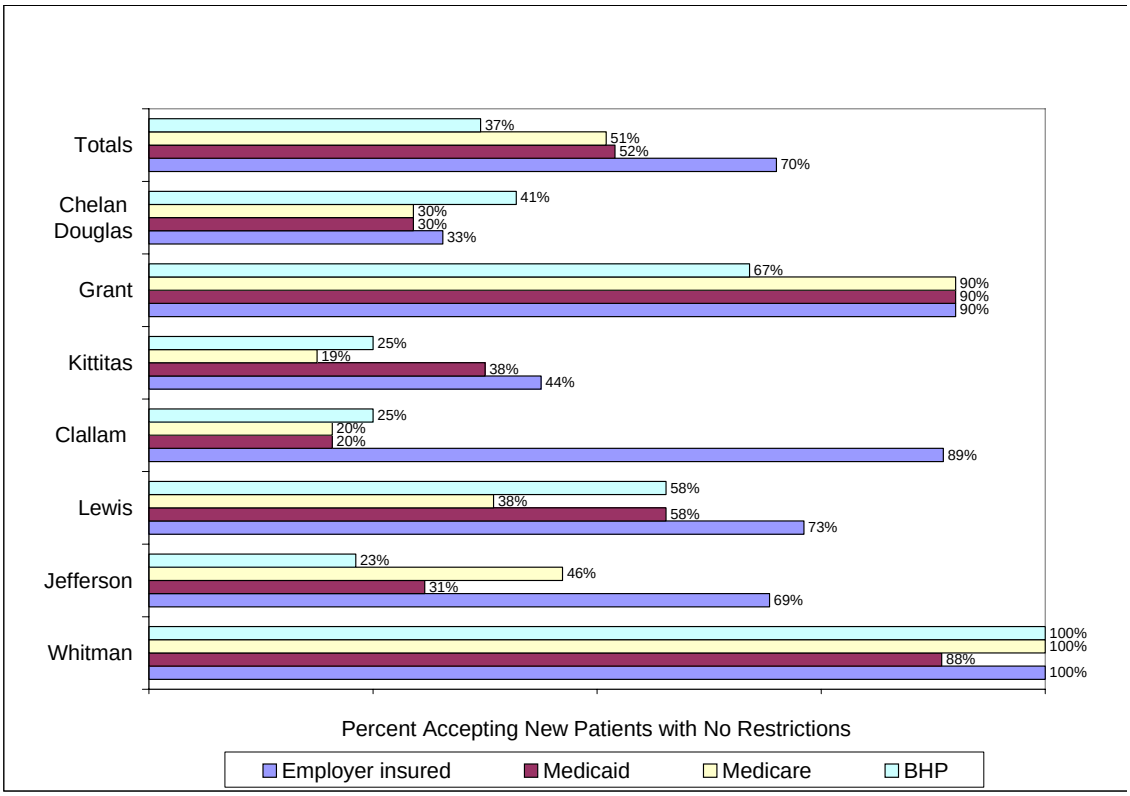
Figure 5
Availability of Primary Care Physician to New Patients
In Selected Washington Counties by Payer, 2002 - 2003



Source: Office of Community and Rural Health

As with other indicators of access to primary care, the survey data show considerable variation across rural counties. For example, most practices in Whitman County were open in part because that community is home to a major state university and a large share of the population had health insurance. In Grant County, where 100% of providers received reimbursement enhancements as either Rural Health Clinics or Community Health Centers, publicly financed patients experienced a high level of access to care. More practices were closed in counties that had fewer practices receiving reimbursement enhancements (Clallam, Kittitas, Lewis and Jefferson), more Medicare and Medicaid enrollees (Clallam, Jefferson, and Lewis), and general provider shortages (Kittitas and Chelan – Douglas) at the time of the survey even though none of its community clinics was receiving reimbursement enhancements. Many of the clinics Clallam, Kittitas, Jefferson and Lewis counties have since converted to Rural Health Clinic status and access may improve. The chart below shows how markedly access for new public patients varies across counties.

Figure 6
Availability of Primary Care Physician to New Patients
In Seven Rural Washington Counties by Payer, 2002 – 2003



Source: Office of Community and Rural Health

Medical and Public Transportation

Residents of rural areas without the ability to own and operate a private vehicle face an additional barrier to receiving primary health care services. Of Washington's 27 rural counties, 14 have no public transit system at all, and 5 do not offer public transit outside town limits. In the eight rural counties that do offer public transit to outlying areas, routes are often limited to a few trips per day and are not offered on evenings and weekends. Transit options are equally limited in the rural parts of urban counties. Medical transportation in rural counties is provided by a patchwork system that includes Medicaid transportation brokers, local hospitals and health districts, faith-based and community groups, and emergency medical and trauma systems.

The medical transportation problem is especially acute for those with developmental disabilities and other conditions that local providers may be untrained or unwilling to treat.

For more information, see two reports from the Washington State Department of Transportation:

- 2003 Summary of Washington Public Transit
- Special Transportation Needs Study

High-risk Populations

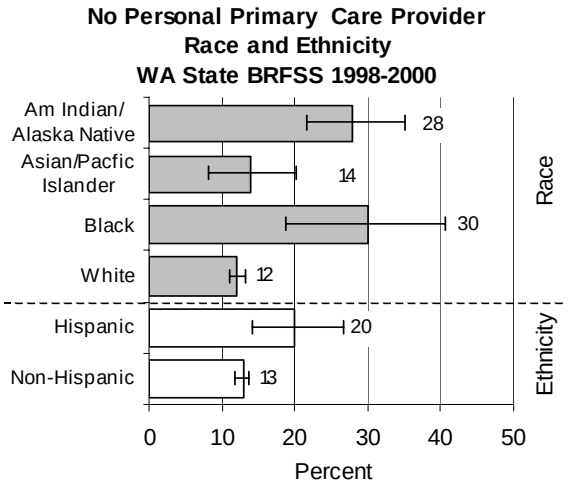
American Indians and Hispanics—especially migrant and seasonal farm workers— are the least likely populations to have a personal primary care provider.

Nearly a third (29%) of the Washington's American Indian population lives in large and small-town rural areas of the state. Access to primary care is poor because the Indian health care delivery system is fragmented and not always well-integrated with the non-Indian health care system. Both Indian Health Centers and many tribally operated clinics are chronically under funded. Many Indian Health Service facilities are open only during weekdays and don't provide coverage in the evenings.

Nearly half (49%) of Washington's 289,000 migrant seasonal farms workers and their dependents in Washington live in rural counties. Another 48% live or work in Benton, Franklin, or Yakima counties—many in the outlying rural parts. The migrant and seasonal populations have low family incomes and limited transportation options, and they face additional language barriers[iii].

The following chart shows the shares of the Indian and Hispanic populations that lack access to primary care.

Figure 7



Source: 1998-2000 BRFSS, Health of Washington State, 2002

For more information on health care disparities for the Washington's American Indian population, see

American Indian Health Commission of Washington

Technical Notes

Primary care ratios: Primary care staffing ratios reported for 1998 in Health of Washington State 2002 were calculated by the Center for Health Workforce Studies using the 1998 Health Professional Licensing Survey. 1 Full-time equivalent (FTE) = 105/visits/week and 48 weeks a year based on self-reported survey data. Primary care providers include family practice, pediatrics, and general internal medicine Primary care staffing ratios reported for 2002 and 2003 were calculated by the Office of Community and Rural Health using county Health Professional Shortage Area survey data that asked only hours of direct patient care. 1 FTE = 40 hours of direct patient care. The office also includes OB/GYN physicians as primary care providers and rounded county ratios to the nearest 100. Because these studies calculated ratios differently year to year, comparisons are not appropriate.

Estimating the Uninsured: Estimates of the number of uninsured vary from survey to survey because of the way questions are asked about insurance coverage. The State Population Survey uses a conservative method that asks whether persons have specific insurance at the current time. Estimates from the Census Bureau's Current Population Survey are higher because they include all those people that were uninsured at the time of the survey as well as those reported they were uninsured at any time in the prior year. Recollection also inflates insurance estimates.

Definitions of rural: Comparisons of demographic trends over time in rural areas is complicated. In addition to the population growth or decline, the specification of "rural" is a moving target. Not only are there different systems for classifying what is rural, but also, the classification methods within each system have changed since 1990, as has the underlying geography (Census tract numbering and boundaries). Caution should be exercised when making comparisons over time, since some of the change is the result of changes in definitions and classification schemes. This monograph classifies the rural areas using the Rural Urban Commuting Area (RUCA) system for most comparisons. For a more detailed discussion of alternate rural classification methods, see
http://www.doh.wa.gov/Data/Guidelines/RuralUrban.htm

The RUCA system classifies Census tracts using Census Bureau definitions of urbanized areas and urban clusters to define urban areas, large town (10,000 to 49,999) and small town (2,500 to 9,999) core areas, and isolated rural areas. Adjacent Census tracts are defined on the basis of their commuting relationship (greater than 30% commuting) to these core areas. Individual Census tracts are classified into 10 major classes, ranging from urban core to isolated rural areas. For a detailed description of this system, see http://www.fammed.washington.edu/wwamirhrc/

For this analysis, we consolidated the 10 RUCA classes into four: urban core areas, urban-rural fringe areas (areas with a strong commuting relationship to urban cores), large town areas, and small town and isolated rural areas. The current RUCA system was built using 1990 Census tracts and commuting data and is currently being revised. The update is expected out in late 2003. Consequently, when we compare changes over time, we are comparing what has changed within areas that were classified as urban, urban-fringe, large town, and small town in 1990. For example, three large town areas in the state were reclassified as urbanized in the 2000 Census. In the RUCA-based analyses, these areas remain in the large town category. This is a not-unreasonable assumption because the population in these areas grew from slightly less than 50,000 to slightly more than 50,000.

Data reported in the State Population Survey are available only by regions.

End Notes

[i] Hart G F et. al. Physician staffing ratios in staff-model HMOs: a cautionary tale. Health Affairs, 2001 Oct.

[ii] Baldwin L. et. al. Rural and urban physicians: does the content of their practices differ? WWAMI Rural Health Research Center, University of Washington. Working Paper #48. 1998 May.

[iii] Larson A. Migrant and Seasonal Farmworker enumeration profile study: Washington. Migrant Health Program, Bureau of Primary Care, Health Resources and Services Administration. Bethesda MD, 2000 Sept.